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A prescription for improvement and the dispensing practice scheme

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In our series on the history of prescribing policy, Professor Darrin Baines traces how successive governments have attempted to curb drug costs. Here, he describes the impact of *A Prescription for Improvement* and the renegotiation of arrangements for dispensing doctors.

KEY EVENTS

- 1993 NAO publishes report on repeat prescribing – advisors in only 34 of the 90 FHSAs involved in repeat prescribing reviews
- 1994 Audit Commission publishes *A Prescription for Improvement* – reports predicts NHS expenditure on drugs could be reduced by £425 million
- 1996 Arrangements for dispensing doctors renegotiated – defeat in High Court forces dispensing doctors to renegotiate with DoH
- 1998 Crown report published – examines prescribing in primary care and recommends on use of group protocols

The introduction of Prescribing Analysis and CosT (PACT) data revolutionised the management of medicines spending in NHS primary care.[1] Previously, the Prescription Pricing Authority (PPA) and its predecessors had only been able to produce annual reports on total pharmaceutical expenditure in each practice. Regional Medical Officers were employed to visit the highest spending prescribers.[2] However, excessive prescribing was defined at a patient (not a practice) level. GPs could only be reprimanded if they prescribed excessively for individual patients on their lists. Little action could be taken if overall costs, for all patients, were very high. The introduction of PACT data, which could be accessed at a practitioner and named drug level, changed the way in which medicine costs were managed locally.

Drug budgets

The first major change that the PACT system permitted was the introduction of pharmaceutical budgets under the auspices of the fundholding and indicative prescribing schemes.[3] As these schemes set budget allocations for each practice, GPs were given a new incentive to examine and managed their medicine spends. In response, many greatly increased their generic prescribing rates, which had historically been low. To support local efforts to manage drug budgets, many Family Health Services Authorities (FHSAs) employed medical or pharmaceutical advisers. In the main, they focused on providing willing practices with advice on how to make obvious savings in their drug spends, without rationing care to patients. Therefore, the move to budgeting removed unnecessary spending from the NHS drugs bill through changes to prescribing locally.

With the introduction of PACT data and drug budgets, for a while prescribing became a topic of great interest to policy makers and their advisers. For instance, during the early 1990s both the National Audit Office (NAO) and the Audit Commission published reports on prescribing in NHS general practice. In 1993, the NAO published the results of its study of repeat prescribing in NHS general practice, which found that medical and pharmaceutical advisors in only 34 of the 90 FHSAs had undertaken, or proposed to undertake, an examination of repeat prescribing in local practices.[4] Where they had completed an examination, the audit office found that prescribing advisors had concluded that the effectiveness and efficiency of repeat prescribing could be improved. In response, the NAO recommended that all practices should develop a repeat prescribing policy and that all FHSAs should distribute appropriate guidelines on the subject.

A Prescription for Improvement

In 1994, the Audit Commission published its report *A Prescription for Improvement: Towards More Rational Prescribing in*

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General Practice,[5] the results of its study of prescribing in 54 practices in 10 FHSAs. After analysing prescribing decisions the report concluded that the NHS expenditure on drugs could be reduced by £425 million if GPs made greater use of expenditure control strategies such as increased prescribing of the top 20 generic drugs, substitution of comparable but cheaper drugs, appropriate use of expensive preparations, prescription of fewer drugs of limited clinical value, and less use of drugs often over prescribed. To accompany its report, the Audit Commission made available to all FHSAs what it termed the Thematic Analysis of Prescribing (ACTAP) data-set, which contained information on the savings that individual practices could generate through the use of such strategies.

After suggesting five main categories in which prescribing expenditures could be controlled, the report suggested that substantial savings could be realised through improved management of prescribing shared by hospitals and GPs, greater incentives for family doctors to improve their drug usage, better education, information and support for prescribers, improved communication with patients, and more time and resources for FHSAs. The commission's report concluded by detailing 'the way forward' for practice-level prescribing policy, suggesting that each FHSA needed a clear prescribing strategy, the starting point of which should be 'an agreed vision of what constitutes rational prescribing'.

In a *BMJ* editorial, Judy Gilley, joint deputy chair of the GMSC, responded to *Prescription for Improvement* by arguing that, while family doctors 'will undoubtedly want to address the Audit Commission's proposals constructively', the scope for realising the envisaged savings 'will ultimately depend on an equally constructive approach from the Department of Health to GPs' ever increasing workload'.[6] Although she believed that measures designed to help with workloads could improve the rationality of their prescribing, Dr Gilley also warned that: 'for GPs to follow the Audit Commission's recommendations they will need reassurance that their savings are not going to be negated by the pharmaceutical industry increasing its prices under the Pharmaceutical Price Regulation Scheme (PPRS)'.

Four months after the publication of the Audit Commission's report, the NHS Executive held a national conference at the Metropole Hotel, Birmingham, which examined the ways in which the contracting process could be used to improve drug usage in the NHS. Based upon the conference's findings, the NHSE issued new guidelines in September 1994 on purchasing and prescribing. They indicated the need for FHSAs to take a strategic approach to drug usage across the primary/secondary care interface, particularly in relation to ensuring the appropriateness of hospital-led prescribing and developing an authority-wide policy for the managed entry of new drugs.[7]

As part of these arrangements, the NHSE expected all health authorities (HAs) to establish Joint Prescribing Committees, which would involve clinicians and other key professionals in the development of local prescribing action plans.[8]

National Prescribing Centre

The mid-1990s was a period during which future policy options were considered and stock was taken of many of the initiatives already in place.[9,10,11] At this time, attempts were also made to evaluate the advantages of involving pharmacists and practice nurses in general practice prescribing and of developing the PRODIGY prescribing decision support system.[12,13,14] Given the success of some of the existing initiatives, the Conservative government focused on improving GP prescribing by bettering the co-ordination of local prescribing information, education and research, and introducing further piloting of the more promising local initiatives.

As a result, the National Prescribing Centre was established in April 1996 with the role of promoting 'high quality, cost-effective prescribing through a co-ordinated programme of activities for HAs, prescribing advisors and GPs'.[15] The government also extended the piloting of joint pharmacist and GP working, nurse-led prescribing and the PRODIGY system.[16]

Dispensing practice scheme

During the mid-1990s, the DoH, the BMA and representatives of the pharmaceutical profession became involved in further negotiations and disputes over the dispensing practice scheme. In January 1996, the DoH offered rural doctors a new deal under which pharmacy contractors would no longer be allowed to establish businesses in rural areas without an assessment of whether local medical services would be adversely affected.[17] In return, dispensing doctors in market towns would have to give up their right to supply drugs to patients living more than a mile from a pharmacy, if their surgeries were within half a mile of a pharmacist's shop.

Given the effect that such a move could have had on many rural GPs, the GMSC rejected the DoH's proposals and decided to pursue the issue of rural dispensing in the high court. In consequence, the matter was considered by Lord Justice Schiemann in November 1996, who ruled that HAs were not obliged to consider the effects on local medical services (or the revenues of rural GPs) when deciding whether to grant permission for a new community pharmacy to open.[18] Given that further legal action would be difficult to take, in January 1996 the GMSC decided to accept the judge's ruling and to negotiate a new deal along the lines of the proposals offered by the DoH.[19]

In 1996, the Conservative government's white paper *NHS, Primary Care: Delivering the Future*, announced that a professional working party would be instituted to develop a consistent framework to determine in what circumstances health professionals could undertake new roles with regard to the prescribing or the supply of medicines, and consider the implications of such changes for legislation and professional training.[20]

In consequence, a review team, chaired by Dr June Crown, President of the Faculty of Public Health Medicine, was established in March 1997 to examine the existing (and possible future) arrangements for prescribing, supplying and administering medicines within the NHS. However, as the Labour party won the May 1997 general election, the Conservative government was not in power when the review's first report was published in April 1998.[21]

References

See online version at www.prescriber.co.uk.

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